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Office of Administrative Law Judges
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Issue Date: 17 May 2004

In the Matter of:

MORELLE MULLINS
Claimant

Case No.: 2003 BLA 5495

v.

PLOWBOY COAL CO./
CONTINENTAL INDEMNITY CO.,
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:
Mr. Ron Carson, Representative
For the Claimant

Mr. H. Ashby Dickerson, Attorney
For the Employer/Insurer

Before:
Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. Morelle Mullins for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim

Mr. Mullins filed his first application for black lung disability benefits on November 18, 1982. After the case was investigated by the District Director, his claim for benefits was denied

on April 12, 1983 for failure to show that he was totally disabled. Mr. Mullins did not appeal the decision (DX 1).[1]

Second Claim

On June 2, 1986, Mr. Mullins filed his second claim. After the case was investigated by the District Director, his claim for benefits was denied on October 20, 1986 for failure to show the presence of pneumoconiosis, that the disease was caused by coal mine work, and that he was totally disabled. Mr. Mullins did not appeal the decision (DX 2).

Third Claim

On January 20, 1998, Mr. Mullins filed his third claim. After the case was investigated by the District Director, his claim for benefits was denied on April 16, 1998 for failure to show that he was totally disabled. Eventually, the case proceeded to a conference in which a proposed order and memorandum was issued on June 16, 1998, denying Mr. Mullins' claim for failure to establish total disability. Mr. Mullins did not appeal the decision (DX 3).

Fourth, and Present Claim

On April 9, 2001, Mr. Mullins filed his fourth and present claim (DX 5). On April 25, 2002, the District Director issued a notice indicating that Mr. Mullins would be entitled to benefits if a decision was issued at that time; however, the parties were provided an opportunity to file additional evidence (DX 21). After a review of additional evidence, the District Director awarded benefits to Mr. Mullins on November 18, 2002, finding complicated pneumoconiosis, the associated presumptions, and a material change in condition (DX 27). The Employer filed a timely appeal on November 26, 2002 (DX 29). Due to the Employer's appeal, the District Director initiated the payment of interim benefits and forwarded the case to the Office of Administrative Law Judges on February 27, 2003 (DX 39). Pursuant to a Notice of Hearing, dated April 4, 2003 (ALJ I), I conducted a hearing in Abingdon, Virginia on June 10, 2003 attended by Mr. Mullins, Mr. Carson and Mr. Dickerson.

Evidentiary Discussion

Claimant's Chest X-Rays

Initially, Mr. Mullins' personal representative indicated that he was presenting Dr. Paranthaman's interpretation of the May 31, 2001 chest x-ray, DX 12,[2] and Dr. Alexander's

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

[2]Upon review of the regulations, I note that Dr. Paranthaman's chest x-ray interpretation was part of the pulmonary examination provided by the U.S. Department of Labor ("DOL"). According to 20 C.F.R. § 725.406 (b), the results of the DOL pulmonary evaluation "shall not be counted as evidence submitted by the miner under § 725.414." A complete pulmonary evaluation includes a report of physical examination, a pulmonary function study, a chest roentgenogram and a blood gas study. 20 C.F.R. § 725.406 (a).

evaluation of the August 3, 2001 chest x-ray, CX 3, as his case-in-chief (TR, page 15). Then, almost immediately, the representative identified Dr. Alexander's evaluation of the August 1, 2001 chest film and Dr. Miller's interpretation of the February 3, 2003 chest x-ray, CX 1, as the case-in-chief evidence (TR, page 16). Later in the hearing, the representative stated Dr. Alexander's interpretation of the August 1, 2001 chest x-ray was a rebuttal x-ray. This presentation raises the question of whether Dr. Alexander's evaluation is part of the case-in-chief or rebuttal evidence.

To resolve the confusion, I note that the Employer's counsel identified Dr. Wheeler's interpretation of the August 2, 2001 film as part of the Employer's case-in-chief. In light of that representation, I will consider Dr. Alexander's review of the same film to be a rebuttal chest x-ray interpretation.

Employer's Chest X-Rays

At the hearing, counsel for the Employer offered two interpretations of the May 31, 2001 chest x-ray taken as part of the DOL examination (TR, pages 23 and 24). Both Dr. Scott's interpretation of the May 31, 2001 chest x-ray, EX 1, and Dr. Wheeler's interpretation of the same film, DX 26, were admitted into evidence.

However, upon review of 20 C.F.R. § 725.414 (a) (3) (ii), I note that the Employer is entitled to only one rebuttal chest-ray interpretation to DOL's May 31, 2001 chest x-ray. In his closing brief, Employer's counsel offers Dr. Wheeler's interpretation of the May 31, 2001 chest x-ray, DX 26, as rebuttal evidence, rather than Dr. Scott's interpretation, EX 1. In light of the regulation's evidentiary limitation on rebuttal evidence, and counsel's post-hearing brief, I conclude that Dr. Scott's evaluation of the May 31, 2001 chest x-ray, EX 1, is inadmissible. Accordingly, I will not consider Dr. Scott's interpretation; EX 1 is now marked "offered, not admitted" and will be attached to the record.

CT Scans

Also, at the hearing, the Claimant, through his representative, sought to admit two interpretations of the April 2, 2001 chest CT scan. According to 20 C.F.R. § 718.107 (a), the regulation governing the submission of other medical evidence, the results of any medically acceptable test reported by a physician and not addressed in the regulations may be admitted if it tends to demonstrate the presence or absence of pneumoconiosis. Therefore, I will consider both Dr. DePonte's interpretation of the April 2, 2001 CT scan, admitted as DX 18 and Dr. Alexander's interpretation of the same study, also admitted as DX 18.

In response to the two interpretations of the April 2, 2001 chest CT scan submitted by the Claimant, Mr. Dickerson, on behalf of the Employer, offered Dr. Wheeler's interpretation, EX 2, and Dr. Scott's interpretation, DX 24, of the CT scan in rebuttal. At the hearing, since counsel for the Employer selected EX 2 as its principal interpretation, I admitted EX 2 and deferred a decision on the consideration of Dr. Scott's interpretation, DX 24 (TR, page 25 to 30). Upon review of the regulation, I note that 20 C.F.R. § 725.414(a) (3) (ii) allows the responsible operator one physician's assessment of each piece of evidence submitted by the Claimant under

20 C.F.R. § 718.107. Since the Claimant submitted two interpretations of the April 2, 2001 CT scan, the Employer is permitted to submit one assessment in response to each piece of evidence admitted. Therefore, I also admit Dr. Scott's additional interpretation of the April 2, 2001 CT scan.

Medical Reports

Dr. Castle

At the hearing, counsel for the Employer presented Dr. Castle's August 15, 2001 medical report, DX 20, as the Employer's case-in-chief medical opinion. In considering the physician's report, I discovered two evidentiary issues. First, Dr. Castle rendered his own interpretations of recent radiographic images. While his evaluations would be relevant, they run up against evidentiary limitations. Second, he reviewed medical evidence concerning Mr. Mullins from 1995 through 2001. The depth and breadth of such a review would certainly provide relevant medical information on Mr. Mullins' present pulmonary condition. However, the new regulatory evidence limitation at 20 C.F.R. § 725.414 (a) (3) (i) states:

> [a]ny chest x-ray interpretations, pulmonary function test results, blood gas studies…biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a) (4) of this section.

In response, due regulatory restrictions, and since the Employer has already reached its evidentiary limit for its case-in-chief chest x-rays and physician responses to the Claimant's two CT scans, I must exclude the otherwise potentially probative, and certainly relevant, medical evidence consisting of: a) Dr. Castle's interpretation of the August 1, 2001 chest x-ray, in which he did not find large opacities but did diagnose pneumoconiosis, category 1/1, type r/q opacities; b) his review of the April 2, 2001 CT scan taken on April 2, 2001, in which he found calcified lesions consistent with healed granulamatous disease and some small non-calcified nodules consistent with simple coal workers' pneumoconiosis; and c) his review of medical evidence developed during the adjudication of earlier claims. At the same time, because Dr. Castle segregated his diagnosis based on the medical evidence he obtained during the course of his recent pulmonary examination of Mr. Mullins and his review of other medical evidence, I will consider Dr. Castle's opinion to the extent the objective evidence relied on is admissible under the evidentiary limits established at 20 C.F.R. § 725.414.

Dr. Kanwal

Although the record contains a medical opinion by Dr. Kanwal, DX 25, Mr. Mullins' personal representative did not identify his report as one of the Claimant's case-in-chief medical reports. Yet, since the Claimant's submissions did not exceed the regulatory limit on medical reports, I will consider Dr. Kanwal's April 15, 2002 comments as the Claimant's second medical report under 20 C.F.R. § 725.414 (a) (2) (i).[3]

[3]The medical report by Dr. Paranthaman provided by DOL does not count against the Claimant's limit for medical reports. 20 C.F.R. § 725.414 (b).

Dr. Kanwal did not specify the date of the chest x-ray upon which he based his diagnosis of progressive massive fibrosis. Thus, his opinion raises some concern about compliance with 20 C.F.R. § 725.414 (a) (2) (i), which contains a similar evidentiary restriction as the 20 C.F.R. § 725.414 (a) (3) (i) limitation affecting Dr. Castle's opinion. That is, Dr. Kanwal may have considered an inadmissible chest x-ray. However, upon consideration of this issue, I note that by the time of Dr. Kanwal's evaluation in mid-April 2002, Dr. Paranthaman had interpreted the May 2001 chest x-ray as positive for complicated pneumoconiosis and Drs. Alexander and DePonte had rendered their interpretations of the April 2001 CT scan. Thus, an admissible radiographic evidence of complicated pneumoconiosis was available to Dr. Kanwal at the time of his review and I find no conflict with the evidence limitations.

Dr. Smiddy

Similarly, Dr. Smiddy's March 31, 2001 medical report, CX 5, contains references to objective medical evidence not admissible into the record based on the evidence limitations set forth in 20 C.F.R. § 725.414. Specifically, after reviewing a recent chest x-ray interpretation showing complicated pneumoconiosis, Dr. Smiddy then reviewed Mr. Mullins' "serial films over several years" which "have shown progressive upper lobe changes consistent with progressive massive fibrosis." Thus, "based on looking at the entire series of films all the way back to 1992," Dr. Smiddy concluded Mr. Mullins had coal workers' pneumoconiosis with progressive massive fibrosis.

Unfortunately, Dr. Smiddy did not identify the sources of the multiple radiographic interpretations. These unspecified x-rays are problematic because 20 C.F.R. § 725.414 (a) (2) (i) mandates that "[a]ny chest x-ray interpretations. . . that appear in a medical report must each be admissible under this paragraph or paragraph (a) (4) of this section" (emphasis added). Under 20 C.F.R. § 725.414 (a), chest x-ray interpretations are admissible in only three specific categories: case-in-chief, rebuttal, and treatment/hospitalization record.

Possibly, the chest x-rays were developed during the adjudication of Mr. Mullins' prior claims for black lung disability benefits. The regulation, 20 C.F.R. § 725.309 (d) (1), indicates that evidence from prior claims becomes part of the record in a duplicate claim filed under the new regulations. However, significantly, the evidentiary restriction in 20 C.F.R. 725.414 (a) (2) does not mention that provision. Thus, since Mr. Mullins has reached his limit on case-in-chief chest x-rays, and the unspecified films are not rebuttal, the historical films are not admissible under 20 C.F.R § 725.414 (a) (2) (i).

I have considered the other possibility that the films stem from Mr. Mullins' medical treatment and 1995 hospitalization. However, since Dr. Smiddy did not identify the x-rays as part of Mr. Mullins' medical record, the x-rays are not admissible under 20 C.F.R. 725.414 (a) (4). Accordingly, because the "entire series of films" are not admissible under the provisions of 20 C.F.R. § 725.414 (a) (2), I may not consider Dr. Smiddy's reliance on those films to explain the certainty of his complicated pneumoconiosis diagnosis.[4]

[4]This result presents a vivid example of the adverse effect strict application of the regulatory evidentiary limitations imposes on the development of probative medical opinion.

As with Dr. Castle's report, I will attempt to separate the part of Dr. Smiddy's opinion which is not admissible and consider only the portion that is based on admissible medical evidence.

Response to TB Test

At the June 10, 2003 hearing, I admitted a tuberculosis (TB) test dated June 3, 2003, CX 7, over Employer's timeliness objection and kept the record open for 20 days to give the Employer an opportunity to submit a response to the test (TR, page 14). Subsequently, I did not receive any additional evidence concerning this test.

Summary

In light of the above comments, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 41, CX 1 to CX 8, and EX 2 to EX 5.

ISSUES

1. Whether, in filing a subsequent claim on April 9, 2001, Mr. Mullins has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in June 1998.

2. If Mr. Mullins establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Mullins was a coal miner with post-1969 coal mine employment; b) his length of coal mine employment was at least twenty-two years; and, c) Plowboy Coal Company is the responsible operator in this case (TR, pages 8 and 49).

Preliminary Findings

Mr. Mullins was born on September 15, 1940. He first worked in the coal mines in 1960 and continued intermittently until his last coal mine employment in 1991. Mr. Mullins had to leave coal mining due to knee problems. In his last position as a coal miner, Mr. Mullins worked on the general maintenance of mines and belts where he cleaned and shoveled coal, installed belts, replaced rollers and serviced the head drives at the face of the mine. This work involved dragging, lifting, carrying and loading 50 pound bags of rock dust onto a machine. He also occasionally operated the shuttle car and scoop, which required him to crawl through the mines and lift heavy items while bent over (DX 1, DX 7, DX 9 and TR, pages 33 to 38).

Mr. Mullins began experiencing breathing problems around 1985 that presented as a productive cough and chest pain. Presently, he is unable to walk a short distance or climb stairs without stopping to catch his breath. Dr. Kanwal[5] treats Mr. Mullins with breathing pills, cough syrup and inhalers to improve his condition. Mr. Mullins started smoking at 19 or 20 years old, smoking a pack and a half of cigarettes for 40 years until he stopped two and a half years ago. Mr. Mullins has not been gainfully employed since working in the coal mines in 1991 (TR, pages 38 to 40 and 42 to 46).

Issue # 1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine

[5]The transcript reflects the physician's name as being "Dr. Kimvall" (*see* TR, page 38), but the documents in the record indicate that Dr. Kanwal was Mr. Mullins' treating physician.

[6]20 C.F.R. § 718.202.

employment.[7] Third, the miner has to demonstrate he is totally disabled.[8] And fourth, the miner must prove the total disability is due to pneumoconiosis.[9]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Mullins' case, his most recent, prior claim was finally denied in June 1998 for failure to prove total disability. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since June 1998 to determine whether Mr. Mullins can now prove a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Mullins has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Mullins must demonstrate total respiratory or pulmonary disability

[7] 20 C.F.R. § 718.203 (a).

[8] 20 C.F.R. § 718.204 (b).

[9] 20 C.F.R. § 718.204 (a).

through the presence of complicated pneumoconiosis, pulmonary function tests, arterial blood-gas tests, or medical opinion.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner is suffering from a chronic dust disease of the lung "which then diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C…there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis…"[10] This type of large opacity is called "complicated pneumoconiosis." 20 C.F.R. §§ 718.304 (b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit[11] in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by "congressionally defined criteria." As a result, the statute's definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id*. at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).[12] Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Id*. at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

> if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence

[10]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

[11]Mr. Mullins' case arises within the jurisdiction of this court.

[12]See also 20 C.F.R. §§ 718.304 (b) and (c).

affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id*.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a two-step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence or other diagnostic results exist which are equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities, or their equivalent, exist. Thus, as observed by the *Scarbro* court, definitive evidence indicating the large opacities are not really present would preclude invocation of the 20 C.F.R. § 718.304 presumption.

Second, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence affirmatively shows the large opacities are not what they seem to be due to some other pathology.

Existence of Large Opacities

Due to the absence of any biopsy reports of massive lesions, Mr. Mullins must rely on chest x-ray imaging, or other medical tests, such as CT scans, showing the equivalent of a radiographic image, to establish the presence of large opacities. The radiographic evidence in the record is set out below.

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
May 31, 2001	DX 12	Dr. Paranthaman, B[13]	Positive for pneumoconiosis, profusion 2/2,[14] type p/q opacities,[15] category A large opacity of complicated pneumoconiosis

[13]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[14]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[15]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm)

(same)	DX 12	Dr. Navani, BCR, B	(Film quality reading only) film quality 2, slightly overexposed, suboptimal resolution.
(same)	DX 26	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed a "3 by 2 centimeter angular scar or mass" in the upper right lung, "possible tumor." "Small irregular and nodular infiltrate or fibrosis compatible with TB of unknown activity and probably healed." Possible emphysema.
Aug. 1, 2001	CX 3 & CX 4	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/1, type r/q opacities, 20mm x 10 mm Category A large opacity in right upper lung; could be cancer or complicated pneumoconiosis. Emphysema.
(same)	EX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed presence of 1.5 cm x 1 cm nodule in lower right upper lung, compatible with probably healed TB. Presence of mixed linear, irregular and small nodular infiltrate with probable small calcified granuloma or minimal adjacent linear fibrosis. Dr. Wheeler added, "check for surgery because well defined 5 and 6 cm masses in upper lobes were present on CT scan on 4/2/2001 and are now gone."
(same)	DX 24	Dr. Scatarige, BCR, B	Negative for pneumoconiosis. Observed the presence of linear and nodular opacities that are probably tuberculosis. Probable emphysema.
February 3, 2003	CX 1 & CX 2	Dr. Miller, BCR, B	Positive for complicated pneumoconiosis, profusion 2/2, type t/r opacities, category A large opacity, greater than 10 mm. Emphysema.
(same)	EX 4	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed 2 cm mass or scar on right upper lung and 2 cm angular mass on right lower lung; compatible with healed inflammatory disease; possible granulomatous disease or tumor. Emphysema.

Of the three chest x-rays in the record, there is no dispute concerning two of the films. The May 31, 2001 film is positive for the presence of a large opacity. Although Dr. Wheeler found the film to be negative for pneumoconiosis, his observation of a 3 x 2 centimeter mass indicates the presence of a large opacity in Mr. Mullins' lungs because he describes a large opacity greater than one centimeter in diameter.[16] Dr. Paranthaman observed Category A large opacity as well, which he believed was consistent with complicated pneumoconiosis. Therefore, the May 31, 2001 x-ray establishes the presence of a large opacities greater than 1 cm.

The most recent chest x-ray of February 3, 2003 is also positive for the presence of a large opacity in Mr. Mullins' lungs. Dr. Miller observed a category A large opacity and associated it with complicated pneumoconiosis. Dr. Wheeler observed two 2 centimeter masses that he described as possible inflammatory disease, granulomatous disease or tumors. Again,

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in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[16]20 C.F.R. § 718.340 (a) defines a large opacity as greater than 1 centimeter in diameter, which would be classified in Category A, B, or C under recognized classification systems.

even though Dr. Wheeler did not make a finding of complicated pneumoconiosis and did not describe the opacities he observed as "large," his description of opacities greater than one centimeter in diameter indicates the presence of large opacities. Therefore, the February 3, 2003 chest x-ray is positive for the existence of large opacities.

The remaining chest x-ray generated a medical dispute. In the August 1, 2001 film, Dr. Alexander observed a large opacity that he believed could be complicated pneumoconiosis or cancer. Dr. Wheeler also identified a nodule measuring 1.5 cm x 1 cm, which represents a large opacity. In contrast, Dr. Scatarige did not identify the dimension of any of the observable opacities in the film, which I assume means he did not see a large opacity. Thus, his interpretation does not support a finding that a large opacity is present in the film. All three doctors who reviewed the film are dual qualified radiologists. Consequently, I find the consensus of Dr. Alexander and Dr. Wheeler that an opacity or nodule greater than 1 cm is present in Mr. Mullins' right upper lung represents the preponderance of the medical opinion.[17] Accordingly, I find the August 1, 2001 chest x-ray image contains the presence of a large opacity.

In summary, all three chest x-rays developed since Mr. Mullins filed his present claim contain evidence of a pulmonary opacity greater than 1 cm. Additionally, very little evidence in the record suggests the observed opacities are not actually present. In fact, as set out in the discussion of the CT scans, other probative evidence establishes that the large opacities on the x-ray films represent actual large masses in Mr. Mullins' lungs. Consequently, Mr. Mullins has definitively established the presence of a large opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304 (a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

Other Medical Evidence

Since Mr. Mullins has proven the existence of a large opacity, I move to the second adjudicative step added by the court in *Scarbro* and consider other relevant medical evidence prior to making a determination of whether Mr. Mullins has invoked the 20 C.F.R. § 718.304 presumption. According to the *Scarbro* court, in this second stage of the analysis, I must determine whether the preponderance of the other medical evidence affirmatively shows that large opacities in Mr. Mullins' right upper lung were caused by some other pathology than coal workers' pneumoconiosis. In Mr. Mullins' case, the "other" medical evidence has four components: a) other objective pulmonary test results; b) medical opinion based on pulmonary examination; c) chest CT scan interpretations; and d) comments by physicians who evaluated his chest x-rays.

[17]Dr. Castle also interpreted this chest x-ray and did not see any large opacities. Due to the regulatory evidence restrictions his interpretation is not admissible. However, had his interpretation been admissible, it would not have altered my determination. As dual qualified radiologists, Dr. Alexander and Dr. Wheeler are better qualified in the interpretation of chest x-rays than Dr. Castle, who is just a B reader.

Pulmonary Test Results

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre[18] post[19]	FVC pre post	MVV pre post	% FEV¹ / FVC pre post	Qualified[20] pre Post	Comments
DX 12	May 31, 2001 Dr. Paranthaman	60 67.0″	2.61 2.78	4.72 4.80	140 147	55.3% 57.9%	No[21] No	
DX 20	August 1, 2001 Dr. Castle	60 68.0″	2.45 2.32	3.98 3.67		61.6% 63.2%	No[22] No	Mild airway obstruction
CX 5, CX 6, & EX 5	Feb. 28, 2003 Dr. Smiddy	62 69.0″	2.38	4.34		55.3%	No[23]	Severe obstructive defect

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[24]	Comments
DX 12	May 31, 2001 Dr. Paranthaman	30	75	No[25]	Mild hypoxemia
DX 10	August 1, 2001 Dr. Castle	31.8	81.8	No[26]	

[18]Test result before administration of a bronchodilator.

[19]Test result following administration of a bronchodilator.

[20]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[21]The qualifying FEV1 number is 1.81 for age 60 and 66.9″; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

[22]The qualifying FEV1 number is 1.90 for age 60 and 68.1″; the corresponding qualifying FVC and MVV values are 2.43 and 76, respectively.

[23]The qualifying FEV1 number is 1.93 for age 62 and 68.9″; the corresponding qualifying FVC and MVV values are 2.47 and 77, respectively.

[24]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[25]For the pCO^2 of 30, the qualifying pO^2 is 70, or less.

[26]For the pCO^2 of 32, the qualifying pO^2 is 68, or less.

TB Tests

Dr. Kanwal reported that Mr. Mullins' tuberculosis tests on March 26, 2002 and June 3, 2003 were negative (DX 25 and CX 7).

Discussion

In general, the objective pulmonary test evidence demonstrates Mr. Mullins does not have a significant totally disabling pulmonary impairment. Additionally, most of the physicians to evaluate that data, with the exception of Dr. Smiddy, agreed the test results did not show a total respiratory impairment. However, the absence of other objective medical evidence showing a total respiratory disability does not prevent invoking the presumption under 20 C.F.R. § 718.304 or impeach a finding of complicated pneumoconiosis. The *Scarbro* court emphasized that the statutory scheme does not set out complicated pneumoconiosis in medical terms. Instead, the invocation is based on the radiographic evidence of large, categorized opacities. Further, since the presumption of total disability is irrebuttable, the existence of objective medical evidence to the contrary is not particularly relevant unless that evidence also shows the large opacities are not what they seem to be. Standing alone, Mr. Mullin's non-qualifying pulmonary function tests and blood gas studies, which do not specifically isolate the cause of a pulmonary impairment, do not provide affirmative evidence that the large opacities in his lungs are due to some other pathology. In a similar manner, the two negative TB tests hardly suggest some other etiology is involved. Consequently, I find the other pulmonary tests do not establish some cause other than pneumoconiosis for the large opacities.

Medical Opinions

Dr. S.K. Paranthaman
DX 12

On May 31, 2001, Dr. Paranthaman, board certified in pulmonary disease and internal medicine,[27] conducted a pulmonary evaluation of Mr. Mullins who reported productive cough, wheezing, and shortness of breath on exertion. Mr. Mullins has a coal mine employment history of 25 years. He smoked a pack of cigarettes per day for 25 years, stopping one year before the examination. In the chest x-ray, Dr. Paranthaman observed coal workers' pneumoconiosis and large opacities. The pulmonary function test was normal and the arterial blood gas study revealed mild hypoxemia. Based on the radiographic evidence of larger opacities, Dr. Paranthaman diagnosed complicated pneumoconiosis which was totally disabling. He also believed Mr. Mullins had chronic bronchitis due to smoking and coal dust exposure which caused a mild functional impairment. An arthritic knee prevented Mr. Mullins from engaging in heavy manual labor.

[27]As I informed the parties at the hearing (TR, pages 6 and 7), I take judicial notice of Dr. Paranthaman's board certification and have attached the certification documentation.

Dr. James Castle
DX 20[28]

On August 15, 2001, Dr. Castle, board certified in internal medicine and pulmonary diseases, conducted a pulmonary evaluation of Mr. Mullins who reported shortness of breath and productive cough over the past 10 to 12 years. Mr. Mullins also indicated that he wheezed and experienced chest discomfort. Mr. Mullins was diagnosed with pneumonia in 1995 when he was hospitalized. He has no history of asthma or TB. Mr. Mullins was a smoker of a pack and-a-half of cigarettes per day from the age of 25 through a year and a half prior to the examination, when he was 62 years old, giving him a 35 pack year history. Mr. Mullins takes an inhaler and breathing pills to improve his breathing condition. He worked in the coal mines for 25 years. His last coal mine employment occurred in 1991.

Upon physical examination, the chest was normal. The pulmonary function test indicated a mild airway obstruction. The blood gas study was normal. Dr. Castle finally diagnosed simple coal workers' pneumoconiosis but did not find evidence of complicated pneumoconiosis. Additionally, he noted pulmonary emphysema caused by cigarette smoking. This pulmonary condition caused a mild airway obstruction, which did not render Mr. Mullins totally disabled from a respiratory standpoint.

Dr. Joseph Smiddy
CX 5[29]

On March 31, 2003, Dr. Joseph F. Smiddy, board certified in internal medicine, conducted a pulmonary evaluation of Mr. Mullins who reported productive cough, shortness of breath, and wheezing. Mr. Mullins had a history of complicated pneumoconiosis, emphysema and pneumoconiosis. He was taking medication to aid his breathing. Mr. Mullins worked in the coal mines for 23 years and experienced heavy exposure to coal dust and some exposure to rock dust. He last worked in the coal mines in 1991. Mr. Mullins smoked cigarettes from the age of 21 to 59.

Upon physical examination, the chest was normal. Dr. Smiddy reviewed Mr. Mullins' most recent chest x-ray reading by Dr. Miller and agreed with the radiologist's finding that Mr. Mullins has dense complicated pneumoconiosis with multiple pneumoconiotic nodules. He also reviewed Dr. DePonte's reading of the April 2001 CT scan which showed severe pneumoconiosis and progressive massive fibrosis. Moreover, considering Mr. Mullins was using bronchodilator therapy, Dr. Smiddy concluded the results of the February 2003 pulmonary function test showed a severe obstructive ventilatory defect. Dr. Smiddy believed Mr. Mullins has an obstructive defect that renders him one-hundred percent totally disabled; he is unable to return to coal mining. The physician prescribed continued bronchodilator therapy.

[28] *See* evidence discussion.

[29] *See* evidence discussion.

Dr. Kanwal
DX 25, CX 7, and CX 8

On April 15, 2002, Dr. G. S. Kanwal stated he had treated Mr. Mullins' pulmonary problems since 1994. Mr. Mullins reported a history of shortness of breath and cough. He worked in the coal mines for 25 years, ending his coal mine employment in 1991. Dr. Kanwal noted that a TB test taken on March 26, 2002 was negative for the presence of TB. Based on Mr. Mullins' x-rays and CT scan, Dr. Kanwal believed Mr. Mullins had coal workers' pneumoconiosis and "has developed massive pul. fibrosis interstitial." Mr. Mullins pulmonary condition was related to his former coal miner occupation. Dr. Kanwal administered a second test for tuberculosis on June 3, 2003; the result was negative.

Discussion

The physicians to consider Mr. Mullins' lung condition disagree on whether he has complicated pneumoconiosis. Dr. Paranthaman, a board certified pulmonologist, diagnosed Mr. Mullins with complicated pneumoconiosis, noting category A opacities. Dr. Smiddy found "severe pneumoconiosis with progressive massive fibrosis."[30] This diagnosis is consistent with a finding of complicated pneumoconiosis. Notably, the Supreme Court recognized complicated pneumoconiosis as "involv[ing] progressive massive fibrosis as a complex reaction to dust and other factors." *Usery v. Turner Elkhorn Mining Co*., 428 U.S. 1, 7 (1976). Moreover, the Fourth Circuit commented that complicated pneumoconiosis is also known "by its more dauntingly descriptive name, 'progressive massive fibrosis'." *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1359 (4th Cir. 1996). For that reason, Dr. Smiddy's medical opinion essentially renders a diagnosis of complicated pneumoconiosis and is therefore consistent with the radiographic evidence as well. In a similar manner, Dr. Kanwal diagnosed Mr. Mullins with "coal workers' pneumoconiosis with massive pulmonary fibrosis interstitial," also rendering a complicated pneumoconiosis diagnosis.

Only Dr. Castle, another board certified pulmonologist, provided an opinion that Mr. Mullins does not have complicated pneumoconiosis. While that assessment seems to provide some tangible evidence that the large opacities are not complicated pneumoconiosis, his opinion is outweighed by the concurrence of Dr. Paranthaman, Dr. Kanwal, and Dr. Smiddy.

Additionally, his assessment loses probative value concerning the etiology of Mr. Mullins large opacities because he did not believe any large opacities existed. Dr. Castle reached his conclusion about the absence of large opacities based on his own interpretation of the August 1, 2001 chest x-ray and April 2001 CT scan. As previously discussed, under the regulations, Dr. Castle's interpretations are not admissible; consequently, his conclusion based on inadmissible evidence loses its effectiveness. Further, even if Dr. Castle's interpretations were admissible, they are inconsistent with my determination that all three chest x-rays, including the August 2001 film reviewed by Dr. Castle, contain images of larger opacities. Likewise, his observation

[30]Although a portion of his underlying documentation was not admissible, Dr. Smiddy nevertheless appropriately reviewed the February 3, 2003 chest x-ray interpretation of complicated pneumoconiosis and Dr. DePonte's similar interpretation of the April 2001 CT scan.

about the April 2001 CT scan is overwhelmed by the consensus of better qualified radiologists who did see large masses in that study. Consequently, Dr. Castle's opinion that Mr. Mullins does not have complicated pneumoconiosis is hardly probative on the source of large pulmonary opacities which he incorrectly believes are non-existent.

Dr. Castle also emphasized that the pulmonary evaluations indicated Mr. Mullins was not totally disabled and suffers from only a mild impairment. As previously discussed, whether or not other medical tests demonstrate that Mr. Mullins is totally disabled from a respiratory standpoint is irrelevant to the analysis of whether he has complicated pneumoconiosis based on the existence of large opacities in his lungs. Thus, because Dr. Castle clearly relied on his belief that no large opacity is present and such reliance is contrary to my findings, and due to his emphasis on the absence of a demonstrable pulmonary impairment, his conclusion that Mr. Mullins does not have complicated pneumoconiosis has diminished probative value.

In summary, on the issue of complicated pneumoconiosis, Dr. Castle's negative finding has diminished probative value. In contrast, Dr. Paranthaman, Dr. Kanwal, and Dr. Smiddy presented probative opinions indicating Mr. Mullins has complicated pneumoconiosis. The consensus of these three physicians represents the preponderance of the more probative medical opinion. Consequently, the preponderance of the more probative medical opinion does not point to some other etiology of the large opacities.

April 2, 2001 CT Scan

Dr. Michael S. Alexander
DX 18

Dr. Alexander, a B reader and board certified radiologist, read the CT scan taken of Mr. Mullins on April 2, 2001 (DX 18). He observed emphysematous changes and a background of innumerable small (2 to 6 mm) round opacities in both lungs, moderate profusion, which were consistent with coal workers' pneumoconiosis. Bilaterally, in both upper zones, Dr. Alexander found "conglomerate fibrotic masses indicative of complicated pneumoconiosis." The fibrotic mass in the right upper zone was 60 mm in length; the left upper zones fibrotic mass measured 47 mm. Both large masses meet the criteria for Category B complicated pneumoconiosis. Areas of calcification were present in portions of the masses. Dr. Alexander diagnosed Category B complicated pneumoconiosis; moderate profusion of small pneumoconiotic nodules with areas of coalescence; and emphysema.

Dr. Katherine A. DePonte
DX 18

Dr. DePonte, a B reader and board certified radiologist, also interpreted the April 2, 2001 CT scan and found severe centrilobular and bullous emphysema. She also reported the presence of progressive massive fibrosis consisting of small round opacities, particularly in the upper zones and bilateral conglomerate masses with areas of calcification. Dr. DePonte diagnosed severe pneumoconiosis with progressive massive fibrosis; bullous emphysema; and centrilobular emphysema.

Dr. William W. Scott, Jr.
DX 24

Dr. Scott, a B reader and board certified radiologist, read the CT scan taken of Mr. Mullins on April 2, 2001. He observed lineal scars and areas of focal scar with calcified granulomata in both upper lung zones. "The focal scars measure 6 cm x 1.3 cm on the right and 4.6 cm x 1.4 cm on the left." His findings were consistent with healed tuberculosis. Dr. Scott also noted "a few rounded opacities" in the central and upper portions of the lungs. These other opacities were caused by either healed tuberculosis or "silicosis/CWP (coal workers' pneumoconiosis)." Due to the low profusion of the rounded opacities, Dr. Scott concluded "they could not be related to formation of large opacities." Dr. Scott did not believe the large opacities were silicosis.

Dr. Paul S. Wheeler
EX 2

Dr. Wheeler, a B reader and board certified radiologist, read Mr. Mullins April 2001 CT scan. He observed a 6 by 3 centimeter mass in the right upper lung and 5 by 2 centimeter mass on the left upper lung with calcified granulomata and linear scars, compatible with "conglomerate TB." He also observed the presence of calcified granulomata in subcarinal and bilateral hilar nodes compatible with healed TB and histoplamosis. Dr. Wheeler noted the presence of subtle tiny nodule infiltrates in the center and upper lungs compatible with coal workers' pneumoconiosis "and/or TB." However, the profusion of the small nodules "is not enough to give large opacities of cwp." Dr. Wheeler's final diagnosis is probable, healed TB with thin conglomerate masses containing calcified granulomata in the upper lungs, moderate emphysema and minimal TB or CWP with tiny nodules in the central and upper portion, with an amount of profusion too low to cause larger opacities.

Discussion

The CT scan process presents a sectional view of a person's lungs. Interestingly, all four of the dual qualified radiologists who reviewed these sectional images noted the presence of large focal scars, masses, or conglomerate masses bilaterally in the lungs' upper zones. Even more significant, Dr. Alexander, Dr. Scott, and Dr. Wheeler presented remarkably similar measurements (at least in one dimension) for the mass in the right upper lung, with readings of 6 cm in length, 6 cm x 1.3 cm, and 6 cm x 3 cm respectively. These CT interpretations clearly reinforce the chest x-ray evidence showing large opacities in Mr. Mullins' lungs.

Concerning the source of these large masses, the medical experts are evenly split. Dr. Alexander diagnosed his findings as complicated pneumoconiosis. Reaching a similar conclusion, Dr. DePonte indicated Mr. Mullins has progressive massive fibrosis associated with coal workers' pneumoconiosis, which equates to a finding of complicated pneumoconiosis. In stark disagreement, Dr. Scott and Dr. Wheeler believe the cause of the lung scarring is "healed TB." In determining the impact of this evidentiary stalemate, I am guided by the *Scarbro* court's requirement that an affirmative showing must be made that some other pathology caused the large opacities. Absent any other consideration, this evidentiary standoff between equally well

qualified medical experts who evaluated the same CT scan on whether the radiographic imaging shows complicated pneumoconiosis means the requisite affirmative showing is not established.[31]

Upon further evaluation of these four assessments, I also conclude the opinions of Dr. Scott and Dr. Wheeler that healed TB is the cause of large opacities have less relative probative weight because they did not reconcile their conclusions with other medical evidence in the record consisting of two negative tests for tuberculosis. The actual medical impact of those two negative tests[32] is not as important as the fact that neither Dr. Scott nor Dr. Wheeler addressed whether the March 2002 and June 2003 negative TB tests would alter their etiology opinion.

To some extent, Dr. Wheeler's and Dr. Scott's healed TB causation conclusion has further diminished probative value because they explained the large opacities could not be complicated pneumoconiosis since the underlying profusion of simple coal workers' pneumoconiosis was insufficient to cause complicated pneumoconiosis. As previously discussed, the *Scarbro* court emphasized that complicated pneumoconiosis under the Act was not necessarily the same as medical complicated pneumoconiosis. In attempting to explain away the large opacities as complicated pneumoconiosis based on the medical definition of the disease, Dr. Wheeler's and Dr. Scott's rationale is inconsistent with the Act's definition of complicated pneumoconiosis, as interpreted in *Scarbro* – radiographic evidence of a large opacity, not caused by some other pathology.

Finally, I have considered that when Dr. Alexander interpreted the August 2001 chest x-ray in March 2003, about two years after his May 2001 review of the April 2001 CT scan, he indicated the Category A opacity could be either complicated pneumoconiosis or lung cancer. That equivocal diagnosis is less certain than his definitive finding of complicated pneumoconiosis in his CT evaluation. However, I conclude that Dr. Alexander's uncertainty in reviewing the chest x-ray two years after he evaluated the CT scan does not upset the evidentiary balance in regards to the CT scan. A CT scan and chest x-ray are different analytical tools for assessing pulmonary condition with potentially varying degrees of accuracy. Dr. Alexander's hesitancy about the chest x-ray image may simply reflect the differences in the two diagnostic tools. Significantly, the March 2003 x-ray report does <u>not</u> indicate that Dr. Alexander also reconsidered his earlier CT scan diagnosis and thereby changed his mind about the CT images.

[31]Had Dr. Castle's interpretation of the April 2001 CT scan been admissible, it would not have tipped the balance in either direction. The consensus of the better qualified physicians that the CT scans show large masses or opacities clearly outweighs Dr. Castle's less qualified opinion to the contrary.

[32]In his closing brief, page 7, counsel for the Employer stated, "While the claimant has submitted fairly recent reports from Dr. Kanwal suggesting the claimant does not have active TB at the time the testing was done, this is certainly not the same thing as a doctor saying the claimant has never had TB." In response to his assertion, I note that no physician in the record addressed whether a TB test was indicative of <u>only</u> active TB. One medical book, THE MERCK MANUAL 116 (13th ed. 1977), indicates that a reaction to tuberculin test is diagnostic of tuberculous infection, though not necessarily of *active* TB (emphasis in the original text).

Physician Comments on Chest X-rays

Dr. Alexander

As just discussed above, in his March 2003 interpretation of the August 1, 2001 chest x-ray, Dr. Alexander stated the observed large opacity may represent either complicated coal workers' pneumoconiosis or lung cancer. This equivocal diagnosis does not provide a requisite showing that some other cause is responsible for the mass.

Dr. Wheeler

In his review of all three chest x-rays, Dr. Wheeler observed large opacities. However, in his comments on the radiographic evaluation form, he attributed the lung masses to causes other than pneumoconiosis. In his comment on the May 31 2001 x-ray interpretation, Dr. Wheeler indicated the 3 cm x 2 cm mass was a "possible" tumor. That diagnosis fails to rise to the level of an affirmative showing because it's equivocal, presented without further explanation, and no other evidence in the record indicates Mr. Mullins has a lung "tumor."

In his interpretation of the August 1, 2001 chest x-ray, Dr. Wheeler dropped his tumor diagnosis and indicated the identified large mass was "probably healed TB." While this diagnosis is more assertive than "possible" TB, Dr. Wheeler still did not address the effect the two negative TB tests may have on his probable TB diagnosis. Additionally, any reliance on the certainty of his causation conclusion is negated by his subsequent consideration of the lung mass in the February 2, 2003 chest x-ray when Dr. Wheeler presented three alternative causes for the large opacity, including a return to the tumor theory.

In his evaluation of the February 3, 2003 chest film, Dr. Wheeler suggested the large opacities he observed were due to either a healed inflammatory disease, granulomatous disease, or tumor. These alternative etiologies render his causation determination equivocal.

For the reasons stated above, and considering the varying contents of Dr. Wheeler's explanations from chest x-ray to chest x-ray, I find his comments insufficient to affirmatively establish that some pathology other than pneumoconiosis is responsible for the large lung masses in Mr. Mullins lungs.

In summary, due to the equivocal nature of the chest x-ray comments by Dr. Alexander and Dr. Wheeler, their observations do not satisfy the *Scarbro* affirmative showing of an different etiology.[33]

[33]Again, admission of Dr. Castle's x-ray comments would not have altered the outcome. Since Dr. Castle did not observe any large opacities, his chest x-ray comments do not address the etiology of the large opacities observed by the better qualified radiologists. In contrast, had Dr. Smiddy's review of the historical chest x-rays been admissible, his comments about those films would have been very relevant on the etiology issue. Pointedly, he observed that multiple chest x-rays over the course of years showed the development of opacities in Mr. Mullins' upper lung zones, which is consistent with coal workers' pneumoconiosis with progressive massive fibrosis.

Conclusion

According to the *Scarbro* court, once chest x-rays vividly establish the presence of large opacities as defined by the Act, the invocation of the presumption under 20 C.F.R. § 718.304 is precluded only if an affirmative showing is made that some pathology, unrelated to exposure to coal dust, had caused the lung masses to develop. 220 F.3d at 250. Neither the other objective medical tests, the preponderance of the more probative medical opinion, CT scan interpretations, nor physician x-ray comments provide such sufficient affirmative evidence of a different pathology.

Accordingly, I conclude Mr. Mullins is able to invoke the presumption under 20 C.F.R. § 718.304 through a) the presence of large opacities in the May 31, 2001, August 1, 2001, and February 3, 2003 chest x-rays; and b) the absence of other medical evidence that affirmatively establishes another cause for the opacities unrelated to coal dust exposure.

Through the invocation under 20 C.F.R. § 718.304, Mr. Mullins has proven that he is totally disabled due to pneumoconiosis, thereby establishing that one of the conditions of entitlement that he previously failed to prove (total disability) has changed and is now present. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. Mullins is entitled to black lung disability benefits.

Issue # 2 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Mullins must prove that he has a) pneumoconiosis b) that arose out of his coal mine employment and that he is c) totally disabled d) due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[34] The regulatory definitions include both clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[35] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-ray (§ 718.202 (a) (1)), autopsy or biopsy report (§ 718.202 (a) (2)), regulatory presumption (§ 718.202 (a) (3)), and medical opinion (§ 718.202 (a) (4)). One of the

[34]20 C.F.R. § 718.201 (a).

[35]20 C.F.R. § 718.201 (a) (1) and (2).

regulatory presumptions specified by 20 C.F.R. § 718.203 (a) (3) is the irrebuttable presumption under 20 C.F.R. § 718.304, relating to the presence of complicated pneumoconiosis. Since Mr. Mullins has now invoked that presumption of total disability due to pneumoconiosis, he has proven the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3).

According to the U.S. Court of Appeals in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), on the issue of pneumoconiosis, I must consider all the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis. Since my determination on the issue of the presence of complicated pneumoconiosis required consideration of the medical record in the present claim, including chest x-rays, CT scans, pulmonary testing, and medial opinion, I believe the *Compton* evidentiary considerations requirement have also been satisfied. Further, my review of the earlier medical evidence in the prior claims provided little relevant contrary information on the present state of Mr. Mullins' pulmonary condition – complicated pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. Mullins must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. §718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. As the parties stipulated, Mr. Mullins has at least 22 years of coal mine employment. As a result, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. Mullins' pneumoconiosis and his coal mine employment. The medical evidence contained in the earlier three claims provides little relevant information on whether the pneumoconiosis which Mr. Mullins has now developed is due to some cause other than coal mining. In the present claim, the x-ray comments by Dr. Wheeler and the CT scan comments by Dr. Wheeler and Dr. Scott suggest other causes for the presence of the large opacities. However, I have already determined that their opinions do not sufficiently establish a non-coal dust related pathology. As a result, the causation presumption under 20 C.F.R. § 718.203 (b) has not been rebutted and Mr. Mullins' pneumoconiosis is due to his coal mine employment. Mr. Mullins has proven that he has coal workers' pneumoconiosis.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to pneumoconiosis. Having invoked the 20 C.F.R. § 718.304 irrebuttable presumption, Mr. Mullins has also established these two necessary components for receipt of benefits under the Act.

CONCLUSION

Based on the presence of large opacities in the three most recent chest x-rays, and in the absence of sufficient affirmative evidence showing a non-coal dust related cause, Mr. Mullins has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. That invocation also establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3). Finally, through the presumption in 20 C.F.R. § 718.203 (b), with at least 22 years of coal mine employment, Mr. Mullins is able to establish that his pneumoconiosis was due to his coal mine employment. Having proved each requisite element of entitlement, Mr. Mullins has met his burden of proof and his claim must be approved.

Date of Entitlement

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v.*

Director, OWCP, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Mr. Mullins has not presented definitive chest x-ray evidence or other medical evidence showing that the onset of his total disability occurred before April 9, 2001, when he filed his claim. The first chest x-ray to establish the presence of large opacities, which in turn invoked the presumption of total disability due to pneumoconiosis, was obtained the next month on May 31, 2001. Since there is no showing Mr. Mullins was not totally disabled in the month between the claim filing date and the chest x-ray, his black lung disability benefits are payable beginning April 1, 2001.[36]

ORDER

The claim of MR. MORELLE MULLINS for benefits under the Act is **GRANTED**. PLOWBOY COAL COMPANY and CONTINENTAL INDEMNITY COMPANY are ordered to:

1. Pay Mr. Morelle Mullins all benefits to which he is entitled under the Act and Regulations. Benefits shall commence April 1, 2001;

2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602 (a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. Morelle Mullins;

3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and

4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608 (b).

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: May 17, 2004
Washington, D.C.

[36]I note that the April 2, 2001 CT scan revealed the presence of a large opacity. However, chest x-ray evidence, rather than the CT scan, was the triggering mechanism for invoking the total disability presumption. Additionally, even if the CT scan were used to establish the date of onset, the date of entitlement would still remain April 1, 2001.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties

Certification:

Subramaniam K. Paranthaman, MD

Certified by the American Board of Internal Medicine in:

Internal Medicine and Pulmonary Disease

American Board of Medical Specialties
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